AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		445240	B. WING				05/15	/2013
	PROVIDER OR SUPPLIER RECENTER OF RED	BANK		10	EET ADDRESS, CITY, STATE, ZIP CO 120 RUNYAN DR HATTANOOGA, TN 37405	DDE	· · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD !	BE G	(XS) COMPLETIC DATE
F 241 SS=D	The facility must promanner and in an elenhances each resident	AND RESPECT OF comote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality.	F2	241	This Plan of Correction conscredible allegation of complitude submission of this plan of not an admission that a deficit that one was cited correctly correction is submitted to me established by state and federal	ance. How f correction fency exist This pland tet requires	vever, n is ts or of	
	by: Based on medical and interview, the fa							
	Resident #100 was 17, 2011, and readr diagnoses including Dementia, Anxiety, Heel. Medical record revie Data Set (MDS) dat the resident was total Observation on May resident's room, revibed and dressed in Observation on May resident's room, reviback and dressed in Observation on May revealed the resident of the reside	admitted to the facility on May nitted on May 1, 2013, with Amputation Left Toe, and Decubitus Ulcer Left wo of a quarterly Minimum ed April 10, 2013, revealed ally dependent for dressing. 13, 2013, at 1:00 p.m., in the ealed the resident lying on the a hospital gown.			1. Corrective action Director of Nursing removed signage from doorframe of resident #213 immediately or 05/15/13. CNA assigned to resident #100 offered to change to loose fitting clothin and resident chose not to change on 05/14/13. 2. Identification Director of Nursing removed signage from all other doorframes on 05/15/13. No other residents who wear facility provided gowns were found to be affected.	ng		

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days slowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4L3111

Facility ID: TN3309

If continuation sheet Page 1 of 21

	MO TON MEDICATE	a WEDICAID SERVICES				MD MO	<u>. 0938-039</u> 1
STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY
- 		445240	B. WING	} <u> </u>		05/	15/2013
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF RED	BANK			1020 RUNYAN DR		
	THE OCIVICION INCLU	BANK	.	(CHAȚTANOOGA, TN 37405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From pa	ane 1	F.	241	3. Measures		
· -··	hospital gown.	ge i	F 4	24 1			
	nospitai gown.				Therapy manager, Restorative		
	Interview with Licer	nsed Practical Nurse (LPN) #2			manager, and Director of		1
		it 8:24 a.m., at the 100 hall	,		Nursing were inserviced by		
	Nurse's Station, cor	nfirmed the resident was to be			staff development coordinator		
	dressed in loose pe				on 05/15/13 regarding signage		}
:					and acceptable locations for		İ
	Resident #213 was	admitted to the facility on May			individual patient information. Staff Development		
	2, 2013, with diagno	oses including Fractured	[Coordinator provided inservice		
Vertebrae, Chronic Tract Infection, and		Airway Obstruction, Urinary		I	to staff regarding provision of		
		Anxiety.			choices to residents on wearing	İ	
	Medical record revie	our of a Number Adminster			facility provided gowns on		
	Assessment dated	ew of a Nursing Admission May 2, 2013, revealed the			05/15/13. The Unit		
	resident was alert a	nd oriented			Coordinators will conduct	,	
		ind onemed.		ļ	signage and gown audits		
	Observation on May	y 13, 2013, at 12:11 p.m.,			weekly for 4 weeks then		
	outside the resident	t's room, revealed a sign			monthly for 2 months to		
]	posted "please have	e pt (patient) inup in W/C		j	ensure compliance. The Unit		
1	(wheelchair) by 11:0	00 am daily m-f		i	Coordinators will submit the		
	(Monday-Friday) for	therapy thank you."	I	-	audit results to the Director of		
1	ing. Distance control in the second				Nursing each week.		
i	2013, at 2:37 p.m., i	irector of Nursing on May 15, in the Unit Manager's Office,			4. Monitoring		
	confirmed the sign o	on the resident's door failed to 1		- [The Director of Nursing will	- 1	
	respect the resident'	's dignity and individuality.		1	submit the results of the audits	[
F 242	483.15(b) SELF-DET	TERMINATION - RIGHT TO	F 24	42	to the Quality Assurance	1	
SS=D	MAKE CHOICES	ŀ			Committee, consisting of the		
					Medical Director, Executive		
	The resident has the	right to choose activities,			Director, Director of Nursing,	i	
1	schedules, and near	th care consistent with his or			and at least 3 other staff		
	ner interests, assess	sments, and plans of care;			members, monthly. The	1	
	incide and outside th	ers of the community both			Quality Assurance Committee		
	about aspects of his	ne facility; and make choices or her life in the facility that		1	will review these results and if	[
	are significant to the	resident			deemed necessary by the		
	are eignineant to the	resident.			committee, additional education may be provided:	ŀ	
					the process evaluated/revised	1	,,
	<u> </u>				and or/ the audits reviewed for	-	7/1/13
				<u> </u>	and on the address to viewed for		<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4L3111

Facility ID: TN3309

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<u>~</u>	ZELVI ELIO I ON MICUIOANE A MICUICAID SERVICES				OMB N	O. 0938-039	1
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG	(X3) D/	ATE SURVEY OMPLETED	-
- <u></u>		445240	B. WING _			5/15/2013	
	PROVIDER OR SUPPLIER ARE CENTER OF RED	BANK	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1020 RUNYAN DR CHATTANOOGA, TN 37405	1	31 (312013	_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ULD BE	(X5) COMPLETION DATE	_
	This REQUIREMENT by: Based on medical and interview, the fathonored the resider of the bed for one regresidents reviewed. The findings include Resident #201 was February 27, 2013, Dementia, Muscle V Depressive Disorder Medical record revied Data Set (MDS) date the resident required transfers and locome Medical record revied last updated on April questions that can be Observation on May 4:45 p.m., revealed to Observation on May revealed the resident Observation on May a.m., and 11:40 a.m., in the bed. Interview with the reson May 15, 2013, at 9 resident wanted to get and interview with the resident wanted to get and interview with the resident wanted to get and interview wanted to get and inte	record review, observation, acility failed to ensure staff of the preferences for getting out esident (#201) of forty-four ed: admitted to the facility on with diagnoses including Veakness, Dysphagia, r, and Difficulty Walking. We of the admission Minimum and March 6, 2013, revealed dextensive assistance for option. We of the resident's care plan 1, 2013, revealed "use answered yes or no" 13, 2013, at 11:30 a.m. and the resident lying in bed. 14, 2013, at 7:42 a.m., alying in bed. 15, 2013, at 9:35 a.m., 10:42 revealed the resident lying in dent, in the resident's room, and the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the resident lying in the company of the resident lying in the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the resident lying in the company of the resident lying in the resident lying in the company of the resident lying in the resident lying in the resident lying in the resident lying in the company of the resident lying in the resident lying in the resident lying in the company of the resident lying in the resident lying in the resident lying in the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the resident lying in the company of the company of the resident lying in the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the compa	F 24	2 3 months or until 100% compliance is achieved. The Executive Director will monitor to assure continued compliance.			

CLIVIL	NO LOIZ MEDICARE	A MEDICAID SEKVICES				<u> NMR MÖ</u>	<u>. 0938-039</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445240	B. WING	····		05	/15/2013
NAME OF	PROVIDER OR SUPPLIER	-		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		71072010
LIFE CA	RE CENTER OF RED	BANK			0 RUNYAN DR		
				CH	ATTANOOGA, TN 37405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	D BE	(X5) COMPLETION DATE
F 242	Continued From as	2			F242		 -
1 472			F 2	42			
	bed the resident re	piled "no."	,	- -	Corrective action		
	Interview with Certi	fied Nursing Assistant (CNA)			Resident #201 was immediately		
	#1 on May 15, 2013	3, at 9:35 a.m., outside the			placed in her Geri-chair by CNA	on	
	resident's room, rev	ealed the resident can		1	05/15/13	OII	
	communicate his/h	er needs to the staff.					
	Interview with Licen	and Destination of the state		- 2	2. Identifying other residents		
	on May 15, 2013, a	sed Practical Nurse (LPN) #1	İ		Residents remaining in bed were	•	
	on May 15, 2013, at 11:35 a.m., revealed the resident "can answer yes or no questions." LPN				asked if they wanted to get out of bed by Unit Coordinators on		
	#1 then asked the r	esident if "has been out of bed			05/15/13		
	during the past few	days," the resident replied					
	"no." LPN #1 asked	the resident if "wants to get	İ	3	3. Measures		
	interview revealed t	t replied "yes." Continued he resident's preference to be			Nursing staff inserviced on		
	out of bed was not l	ne residents preference to be			05/15/13 by Staff Development		
F 246	483.15(e)(1) REAS	ONABLE ACCOMMODATION	F 24	16	coordinator related to resident's choices and patient centered care.		
SS=D	OF NEEDS/PREFE	RENCES	1 2	,0	The Unit Coordinators will condu	ıet	
					audits regarding resident choice to))	İ
	A resident has the ri	ight to reside and receive			get out of bed or not, weekly for 4	1	
	services in the facili	ty with reasonable		-	weeks then monthly for 2 months		
	preferences except	individual needs and when the health or safety of		i	to assure compliance. The Unit		
	the individual or other	er residents would be			Coordinators will submit the audit results to the Director of Nursing	ţ.	
	endangered.	or residents would be		- [each week.		
	-						
				4.			
ļ	This DECLUDENCE	T io nott · · ·			The Director of Nursing will		
	by:	T is not met as evidenced		-	submit the results of the audits to		
ļ		ecord review, observation,			the Quality Assurance Committee, consisting of the Medical Director,		
	and interview, the fa	cility failed to accommodate			Executive Director, Director of	'	
	the needs for two re:	sidents (#213, #103) of			Nursing, and at least 3 other staff		
	forty-four sampled re	esidents.			members, monthly. The Quality		
	The findings included	. · ·			Assurance Committee will review		
	The midnigs monder	u. Į		Į	these results and if deemed	ŀ	
	Resident #213 was a	admitted to the facility on May			necessary by the committee, additional education may be	ŀ	11.
					provided: the process		1/ו/ד
RM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: 4L3111	F	acili	evaluated/revised and or/ the audits	on sheet	Page 4 of 21
					reviewed for 3 months or until		. 230 10/21
					· ·		

100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.

<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES	_	0	MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445240	B. WING	-	05/15/2013
	PROVIDER OR SUPPLIER RE CENTER OF RED	BANK	STF 1	REET ADDRESS, CITY, STATE, ZIP CODE 020 RUNYAN DR CHATTANOOGA, TN 37405	03/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
	2, 2013, with diagnod Vertebrae, Chronic, Tract Infection, and Medical record reviet Assessment dated I resident was alert a gestures to communicate the resident was alert and gestures to communicate the resident was alert and phone due to the resident may 15, 2013, at 3:0 room, revealed the resident's house hear conversations. Interview revealed the resident's house hear conversations. Interview with the fact 15, at 3:12 p.m., revet the resident was unfacility phone due to interview confirmed inter	Airway Obstruction, Urinary Anxiety. We of a Nursing Admission May 2, 2013, revealed the nd oriented, used hand nicate, and was partially deaf. Perview with resident #213 on 20 p.m., in the resident's resident sitting on the side of ant was concerned regarding a was unable to use the facility sident was deaf. Further are resident had a phone at the resident could use to communicate on the the partial deafness. Further the facility failed to provide to accommodate the dimitted to the facility on a readmitted on July 18, including Neoplasm of the the Hand Joint, and	F 246	1. Corrective action The Social Services Director provided Resident # 213 with telephone amplifier on 05/16/13 and resident chose not to use the device. Resident #103 bed was extendable and was adjusted on 05/15/13 by Maintenance Supervisor 2. Identifying other residents Residents with hearing impairmen were reviewed by social services on 05/16/13 to assure accommodation of needs with regard to amplified telephones. 100% audit completed by nursing management by observation on the beds on 05/16/13 to assure they are the proper size for each patient 3. Measures Staff inserviced on 05/16/13 by Staff Development Coordinator to assure identification of patients requiring amplified telephones and proper bed size. Admissions nurse, Social Services Director and Social Services assistant were inserviced on 05/21/13 by the Unit Coordinator to assure residents with hearing impairment are assessed for the need for an amplified telephone on admission. The Social Services Director will complete audit of residents for the need for amplified telephones	
M CMS-2567	7(02-99) Previous Versions Op	osolete Event ID: 4L3111	Fac		7/1/3 1 sheet Page 5 of 21

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		NG	COMPLETED	
<u> </u>	· · · · · · · · · · · · · · · · · · ·	445240	B. WING		05/15/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RECENTER OF RED	BANK	- 1	1020 RUNYAN DR CHATTANOOGA, TN 37405		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	 ID	PROVIDER'S PLAN OF CORRECTION	N (ve)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RE COMPLETION	
F 246	F 246 Continued From page 5 Observation on May 15, 2013, at 8:35 a.m., revealed the foot board missing from the end of the resident's bed.		F 24	1 2/2021ROTHIS		
				The Director of Nursing will submit the results of the audits to the Quality Assurance Committee	. !	
Review of the quarterly Minimum Data Set (MDS dated February 6, 2013, revealed the resident's height was 75 inches (6 feet 3 inches).			Executive Director, Director of Nursing, and at least 3 other staf members, monthly. The Onality	r, ff		
	Interview with the re 8:35 a.m., in the res I can get a long mat	sident on May 15, 2013, at ident's room revealed, "I hope tress."		Assurance Committee will review these results and if deemed necessary by the committee, additional education may be		
	on May 15, 2013, at room, revealed the the bed if the reside take the foot boards some long mattress.	enance Workers #1 and #2 8:38 a.m., in the resident's foot board would only be off nt is too tall and "we try to not off the beds; we do have es, and we also have lattresses. The foot boards ir inches."		provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	,	
	May 15, 2013, at 8:4	ed Nursing Assistant #3 on 5 a.m., in the resident's esident's feet hang off the lent) is tall.		F279		
SS=D	15, 2013, at 8:43 a.m confirmed the foot be resident needs a long check on getting the accommodate the re 483.20(d), 483.20(k) COMPREHENSIVE (A facility must use the to develop, review an	(1) DEVELOP CARE PLANS e results of the assessment d revise the resident's	F 279	plan was revised on 05/16/13 by MDS Coordinator to include dental concerns. Resident #80 care plan was revised on 05/16/13 by MDS		
F	to develop, review an comprehensive plan	d revise the resident's		concerns. Resident #80 care plan was revised on 05/16/13 by MDS Coordinator to include fall risk.	7/1/3	

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Event ID: 4L3111

Facility ID: TN3309

If continuation sheet Page 6 of 21

STATEMENT OF DEFICIENCIES (CAL DESCRIPTION OF LANCES					<u> </u>	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		ITE SURVEY	
		445240	B. WING	_	····	0.5	6/15/2013	
	PROVIDER OR SUPPLIER RECENTER OF RED	BANK		10	EET ADDRESS, CITY, STATE, ZIP CODE 020 RUNYAN DR	, <u>v</u>	7.7572010	•
(X4) ID	SHAMADVETA	TENER OF SECTION		<u> </u>	HATTANOOGA, TN 37405			
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE	
	The facility must deplan for each reside objectives and timet medical, nursing, anneeds that are ident assessment. The care plan must to be furnished to ath highest practicable psychosocial well-be §483.25; and any se be required under §4 due to the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on medical reand interview, the factomprehensive care #80) of twenty-nine reforty-four sampled resident #213 was as Resident #213 was as	velop a comprehensive care nt that includes measurable ables to meet a resident's id mental and psychosocial ified in the comprehensive describe the services that are tain or maintain the resident's obysical, mental, and sing as required under rvices that would otherwise 183.25 but are not provided exercise of rights under lie right to refuse treatment It is not met as evidenced ecord review, observation, sility failed to develop a plan for two residents (#213, esidents reviewed of sidents.	F2		 Identification Resident care plans reviewed on 05/15/13 by nursing management team to assure hearing impairments, fall risks, and dental services are properly addressed on admission or with a significant change. Measures Staff development coordinator completed inservice with nursing management team on 05/17/13 regarding review of care plans to include hearing impairments, fall risks, and dental concerns on admission, with a significant change, quarterly with care plan review, and annually with care plan review. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week. Monitoring 			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	z, 2013, with diagnosi Vertebrae, Chronic Aii Fract Infection, and Ai Medical record review	way Obstruction, Urinary exist.			The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of			
r	esident was alert and pose/missing teeth, us	IV 2, 2013, revealed the			Nursing, and at least 3 other staff members, monthly. The Quality Assurance Committee will review these results and if deemed necessary by the committee,		7/1/13	
M CMS_2567/	(02-00) Provious Versians of				יייייייייייייייייייייייייייייייייייייי	1	* 1 * 7 * 1	

		A MEDICAID SERVICES			OMB NO	. 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		re survey MPLETED
		445240	B. WING		05	115/2013
	PROVIDER OR SUPPLIER RE CENTER OF RED	BANK		STREET ADDRESS, CITY, STATE, ZII 1020 RUNYAN DR	PCODE	· ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	CHATTANOOGA, TN 37405 PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	F CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	Medical record revidated May 2, 2013, address the resider needs. Interview with the Li #3 on May 15, 2013 Director of Nursing completed the Interinterview confirmed an Interim Care Plateeth and the reside related to the diagnor Resident #80 was a February 12, 2013, and medical resident #80 was a February 12, and medical resident #80 was a February 12, and medical resident #80 was a February 12, and medical resident #80 was a February 12, and	•	F 2	additional education may provided: the process ever revised and or/ the audit for 3 months or until 100% compliance is achieved. The Director will monitor to encontinued compliance.	raluated is reviewed 6 he Executive	
į	February 12, 2013, r indicating resident w medical record revie plan of care revealed address the fall risk. Interview on May 14, 100 hall nurse's stati Nurse (LPN) #2 con address falls. 483.20(k)(3)(i) SERV PROFESSIONAL ST	ew of a fall risk score dated revealed a score of fourteen ras a high fall risk. Continued w of the resident's current of the care plan did not. 2013, at 4:04 p.m., at the on, with Licensed Practical firmed the care plan did not. ICES PROVIDED MEET ANDARDS d or arranged by the facility hal standards of quality.	F 28	Admissions nurse corrected Resident # 212 Vitamin Med Pass dietary supplicurrent medication admirecord on 05/13/13. Un on 05/13/13 notified M Doctor with no new ord. Identification The nursing manageme completed audit on 05/assure orders correctly upon receipt. Audit con orders received in the fathe period of 04/18/13 to	n D order ement on inistration it Manager edical ders. ent team 13/13 to transcribed inpleted of acility for	7/1/13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					OMB NO.	. 0938-0391
AND PLA	INT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	É SURVEY PLETED
		445240	B. WING) AE	4510040
	PROVIDER OR SUPPLIER ARE CENTER OF RED	BANK		REET ADDRESS, CITY, STATE, ZIP CODE 1020 RUNYAN DR CHATTANOOGA, TN 37405	<u> </u>	15/2013
(X4) ID PREFIX TAG	((EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	DRF	(X5) COMPLETION DATE
	This REQUIREMENty: Based on medical of the facility failed to for one resident (#2 reviewed. The findings include Resident #212 was a 18, 2013, with diagn Coronary Artery Dise Malnutrition. Medical record revied dated April 24, 2013, 1000 units PO (by m (nutritional supplement) (three times daily)" Medical record review recapitulation (recapitulation (recapitulation (recapitulation (recapitulation Record review Administration Record review Administration Record through May 31, 2013 and the Med Pass we Medical record review Administration Record through May 31, 2013 and the Med Pass was prescribed from May 2013. Interview with License on May 13, 2013, at 3 nurses' station, confirm Med Pass were not listed porders and had	record review, and interview, follow the physician's orders 12) of forty-four residents d: admitted to the facility on April oses including Hip Fracture, ease, Osteoporosis, and w of a physician's order revealed "Vit (vitamin) Douth) dailyMed Pass 2.0 ent) 4 oz (ounce) PO TID w of a physician's order revealed "Vit (vitamin) Douth) dailyMed Pass 2.0 ent) 4 oz (ounce) PO TID w of a physician's order revealed the Vitamin Douth) dailyMed Pass 2.0 ent) 4 oz (ounce) PO TID w of a physician's order revealed the Vitamin Douth) dailyMed Practical Nurse (LPN) #2 end Practical Nurse (LPN) #2 end Practical Nurse (LPN) #2 end the Vitamin D and the outher given as the don the May physician's not been given	F 281	Staff Development Coordinator completed inservice on transcription of orders. Unit Coordinators will complete audits of orders received last 10 days of each month to assure accurate transcription. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week. 4. Monitoring The Director of Nursing will submit the results of the audits to the Quality Assurance Committee, consisting of the medical director, executive directive, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review the results if deemed necessary by the committee, additional education may be provided: the process evaluated revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.		
	483.25 PROVIDE CAI	j	F 309		_	11/12
M CMS-256	7(02-99) Previous Versions Obs	Solete Event ID: 41 2111				<u>'!'!'</u>]

Description of Correction Description	CENTE	KS FOR MEDICARE	& MEDICAID SERVICES				MB NO	D. 0938-0391
STREET ADDRESS, CITY, STATE, ZIP CODE 1028 RUNYAN DR SUMMARY STATEMENT OF DEFICIENCES 1028 CHATTANOOGA, TN 37405 CHATTANOOGA, TN 37405 FAGO COntinued From page 9 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The findings included: The findings included: Resident #103 was admitted to the facility on August 31, 2009, and readmitted on July 18, 2010, with diagnoses including Neoplasm of the Brain, Contracture of the Hand Joint, and Herniplegia. Observation on May 14, 2013, at 10:02 a.m., revealed the foot board missing from the end of the resident's bed. Review of the quarterly Minimum Data Set (MDS) dated February 6, 2013, revealed the resident's height was 75 inches (6 fect 3 inches). SUMMARY STATEMENT OF DEFICIENCES THE PROVIDENCE THAT OF THE APPROPRIATE PROVIDENCE THAT OF CREDITOR OF THE APPROPRIATE PROVIDENCE THAT OF CREDITOR OF THE APPROPRIATE CHAPTORY OF THE APPROPRIATE PROVIDENCE THAT OF CREDITOR OF THE APPROPRIATE SUBJECT OF THE APPROPRIATE PROVIDENCE THAT OF CREDITOR OF THE APPROPRIATE CHAPTORY STATEMENT OF CREDITOR OF THE APPROPRIATE PROVIDENCE THAT OF CREDITOR OF THE APPROPRIATE PROVIDENCE THAT OF	STATEMENT AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY
LIFE CARE CENTER OF RED BANK EXAMPLEY STATES, INTERPRETATION OF THE PRECEDED BY THE PRECEDED			445240	B. WING				EMEIOO40
LIFE CARE CENTER OF RED BANK TAG SUMMAN STATEMENT OF DEPICIENCES FREEK TAG SUMMAN STATEMENT OF DEPICIENCES GEACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) F 309 Continued From page 9 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to ensure a mattress was of the appropriate size for one resident (#103) of forty-four residents reviewed. The findings included: Resident #103 was admitted to the facility on August 31, 2009, and readmitted on July 18, 2010, with diagnoses including Neoplasm of the Brain, Contracture of the Hand Joint, and Hemiplegia. Observation on May 14, 2013, at 10:02 a.m., revealed the resident lying in bed with the feet hanging over the foot of the bed. Observation on May 15, 2013, at 8:35 a.m., revealed the foot board missing from the end of the resident's bed. Review of the quarterly Minimum Data Set (MDS) dated February 6, 2013, revealed the resident's height was 75 inches (6 feet 3 inches).	NAME OF F	PROVIDER OR SUPPLIER		<u></u> 1	STR	FET ADDRESS CITY STATE ZID CODE	1 0:	5/15/2013
### PROPRET IN AND CORRECTION PREFIX TAG PROPRET	LIFE CA	RE CENTER OF RED	BANK		10	20 RUNYAN DR		
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to ensure a mattress was of the appropriate size for one resident (#103) of forty-four residents reviewed. The findings included: Resident #103 was admitted to the facility on August 31, 2009, and readmitted on July 18, 2010, with diagnoses including Neoplasm of the Brain, Contracture of the Hand Joint, and Hemiplegia. Observation on May 14, 2013, at 10:02 a.m., revealed the resident lying in bed with the feet hanging over the foot of the bed. Observation on May 15, 2013, at 8:35 a.m., revealed the foot board missing from the end of the resident's bed is deemed to be incorrect size for patient. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of Nursing each week.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) RE	(X5) COMPLETION DATE
by: Based on observation, medical record review, and interview the facility failed to ensure a mattress was of the appropriate size for one resident (#103) of forty-four residents reviewed. The findings included: Resident #103 was admitted to the facility on August 31, 2009, and readmitted on July 18, 2010, with diagnoses including Neoplasm of the Brain, Contracture of the Hand Joint, and Hemiplegia. Observation on May 14, 2013, at 10:02 a.m., revealed the resident lying in bed with the feet hanging over the foot of the bed. Observation on May 15, 2013, at 8:35 a.m., revealed the foot board missing from the end of the resident's bed. Review of the quarterly Minimum Data Set (MDS) dated February 6, 2013, revealed the resident's height was 75 inches (6 feet 3 inches).		HIGHEST WELL BE Each resident must provide the necessa or maintain the high mental, and psychosaccordance with the	receive and the facility must ry care and services to attain est practicable physical,	F3	09			
1 CMS-2567(02-99) Previous Versions Obsolete	i i i i i i i i i i i i i i i i i i i	Based on observation and interview the fact mattress was of the resident (#103) of for The findings included Resident #103 was at August 31, 2009, and 2010, with diagnoses Brain, Contracture of Hemiplegia. Observation on May 1 be evealed the resident hanging over the foot board he resident's bed. Review of the quarter lated February 6, 2016	on, medical record review, ility failed to ensure a appropriate size for one ty-four residents reviewed. It: It: It: It: It: It: It: It			 Corrective action Resident #103 bed was extendable and was adjusted on 05/15/13 by Maintenance Supervisor. Identification of residents 100% audit completed by nursing management by observation on the beds on 05/16/13 to assure they are the proper size for each patient. Measures Staff Development Coordinator completed inservice for admissions nurse and Treatment Nurse regarding proper bed size and reporting system if bed is deemed to be incorrect size for patient. Unit Coordinators will complete audits weekly for 4 weeks then monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results to the Director of 		
	1 CMS-2567((02-99) Previous Versions Ob-	Solete Event ID: 41 0444			ID. Things		7/1/13

	EDICAID SERVICES		MR NO 0039 020	
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLE CONSTRUCTION G	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	445240	B. WING		05/15/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RED BANK	<u> </u>	ľ	TREET AODRESS, CITY, STATE, ZIP CODE 1020 RUNYAN DR	03/13/2013
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	RE COMPLETION
F 309 Continued From page 10 Interview with the resident I can get a long mattress Interview with Maintenan on May 15, 2013, at 8:38 room, revealed the foot be take the foot boards off the bed if the resident is take the foot boards off the some long mattresses, and extensions for the mattre can be extended four incompart of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the foot board of the resident needs a long mattresses on getting the resident needs a long matcheck on getting the resident of the res	nt on May 15, 2013, at it's room revealed, "I hope it's room revealed, "I hope it." ce Workers #1 and #2 a.m., in the resident's loard would only be off too tall and "we try to not the beds; we do have not we also have sses. The foot boards hes." ursing Assistant #3 on in., in the resident's ent's feet hang off the is tall. Nurse (RN) #3 on May the resident's room, was missing, the tress, and RN #3 would lent a mattress to be theight. IENT/SERVICES - Sive assessment of a ensure that — en able to eat enough and fed by naso gastric is clinical condition in aso gastric tube was	F 309	4. Monitoring	

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		445240	B. WING		05/15/20	013
	ROVIDER OR SUPPLIER RE CENTER OF RED	BANK	-	REET ADDRESS, CITY, STATE, ZIP CODE 1020 RUNYAN DR CHATTANOOGA, TN 37405	1 00/10/20	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COM	(X5) KPLETION DATE
F 322	treatment and servi pneumonia, diarrhe metabolic abnorma	ge 11 ices to prevent aspiration ica, vomiting, dehydration, lities, and nasal-pharyngeal ice, if possible, normal eating	F 322			
	by: Based on medical refacility policy review failed to ensure tube labeled for one residencement of a feed administration of me one resident (#209) residents. The findings include Resident #35 was an 27, 2013, with diagn Insufficiency, Pneuro Chronic Obstructive Hemiplegia, Malnutr Muscle Weakness, an Observation on May	edications and feedings for of forty-four sampled d: dmitted to the facility on April oses including Venous nonia, Decubitus, Dementia, Pulmonary Disease, ition, Depressive Disorder, and Gastrostomy.		322 1. Corrective action The nurse immediately replaced tube-feeding formula on resident #35 on 05/13/13, the tube feeding placement was checked immediately by Staff Development coordinator on resident #209 on 05/13/13 and found to be correctly placed. 2. Identification of residents Audit of all tube feeding was completed on 05/13/13 by nursing managers to assure all		
	Observation on May 13, 2013, at 3:08 p.m., revealed the resident lying in the bed with Pulmocare (therapeutic nutrition for pulmonary patients) infusing at 50 milliliters (ml) per hour per			containers were labeled correctly with both date and time.	7/10	117

		a MEDICAID SERVICES			O	MB NC). 0938-039 [.]	1
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		445240	B. WING			05	/15/2013	
NAME OF I	PROVIDER OR SUPPLIER	-		STR	REET ADDRESS, CITY, STATE, ZIP CODE			•
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			<u> </u>	С	CHATTANOOGA, TN 37405			
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F 322	Continued From pa	ao 40	- -		3. Measures			•
. 022			F 3	322	Staff Development			
	(PEG) feeding tube	Endoscopic Gastrostomy and it did not have a start			Coordinator inservice for all			
	time on the bottle.	and it did not have a start			nurses on 05/16/13 regarding			
					correctly dating, timing, and		,	
	Review of facility po	olicy, Nasogastric/Gastrostomy			signing all enteral formulas			
	Tube Feeding, revis	sed May 21, 2004, revealed			when they are hung for patient			
	and time started"	bag withname, room, date,		ŀ	use. Unit Coordinators will complete			
	and time started			ĺ	audits weekly for 4 weeks then			
	Interview with Licen	sed Practical Nurse #1 on			monthly for 2 months to assure			
	May 13, 2013, at 3:0	08 p.m., in the resident's			compliance. The Unit			
	room, confirmed "it:	should be timed."	ν.	- 1	Coordinators will submit the			
	Resident #200 was	ndmissed seeks 5-199		ļ	audit results to the Director of			
!	12. 2013, with diagr	admitted to the facility on April loses including Right Hip		ŀ	Nursing each week.			
	Fracture and Dysph	agia.			4. Monitoring			
	Observation of a me	edication administration with		ŀ	The Director of Nursing will			
	Licensed Practical N	Jurse (LPN) #5 on May 13.		1	submit the results of the audits			
	: 2013, at 4:48 p.m., r	evealed the LPN entered			to the Quality Assurance			
	(blood thinner), Pop.	n to administer Coumadin		-	Committee, consisting of the			
-	ounce can of Glucer	cid (histamine), and one 8		-	Medical Director, Executive Director, Director of Nursing,			
	observation revealed	d the resident had a			and at least 3 other staff			
	Gastrostomy Tube (1	feeding tube inserted in the			members for two months. The		İ	
	stomach).	-			Quality Assurance Committee			
]	Observation over the				will review these results and if			į
	13 2013 at 5:00 nm	erview with LPN #5 on May n., confirmed "I usually verify			deemed necessary by the			
[placement before oil	ving anything in the tube but I			committee, additional education may be provided: the process	İ		İ
ļ	do not have a stetho:	scope and there is not one			evaluated, revised and or the			Į
1	on my cart." Further	observation revealed the			•			İ
1	LPN administered on	te can of Glucerna 1.5			audits reviewed for 3 months or until 100% compliance is			ļ
	Pepcid, and Coumad	lin without checking the tube			achieved. The Executive Director	i		
į	placement.				will monitor to assure continued	•		
f	Facility policy review	Enteral Nutritional Therapy			compliance.			
	(Tube Feeding) last r	evised May 21, 2004,			•		.,	
		21, 2004,				į.	2/1/12	
				ı				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445240		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONST ING		(X3) DATE SURVEY COMPLETED	
		B. WING		05/	/15/2013		
	PROVIDER OR SUPPLIER RECENTER OF RED	BANK	·	1020 RUN	DRESS, CITY, STATE, ZIP CODE IYAN DR NOOGA, TN 37405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORREC' EACH CORRECTIVE ACTION SHOW LOSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 322 F 371 SS=E	revealed "4. Che Administer the amount interview with Register 2013, at 5:05 p.m., confirmed the tube performed prior to a and/or medications 483.35(i) FOOD PRSTORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and	stered Nurse #2 on May 13, in the south hallway, check placement was to be administering enteral feedings. ROCURE, //SERVE - SANITARY om sources approved or story by Federal, State or local distribute and serve food	F3	F371	Hand washing sink was installed on May 30, 2013. Tice machine drain was		
	by: Based on observatifailed to maintain the sanitary condition. The findings include Observation with the 2013, at 9:40 a.m., a wash station other the Continued observation terms on the food private using as the sanads. Further observations	IT is not met as evidenced ion and interview, the facility e kitchen in a clean and ed: Dietary Manager on May 13, revealed there was no hand han the food preparation sink ion revealed there was food reparation sink in which staff ame sink to wash soiled ervation revealed an ice the kitchen area with a drain		2.	immediately connected durin inspection. Identification All other sinks and ice machine drains were inspected by the maintenance staff. Measurement Dietary manager will observe ice machine drain daily for proper placement and will notify maintenance department if drain is not in working or dietary director will notify administrator weekly if any problems have been noted.	d /e ent	זוור

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Event ID: 4L3111

Facility ID: TN3309

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OMB NO. 0938-0391

OLIVI ENO FOR WIEDICAKE & MEDICAID SERVICES						OMB NO. 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445240		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
<u> </u>			B. WING	·		05	/15/2013
NAME OF F	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u>!</u>		EET ADDRESS, CITY, STATE, ZIP CODE	1 03	110/2013
LIFE CA	RE CENTER OF RED	BANK		10)20 RUNYAN DR HATTANOOGA, TN 37405		
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F 371	Continued From pa and visible green tir machine, touching	nge coming out from the ice	F:	371	Monitoring The Administrator will submit the results of the observations.		
	Interview with the D 2013, at 9:58 a.m., hand wash sink had machine drainage prevent sewage bac Continued interview ensure a sanitary er 483.55(a) ROUTINE SERVICES IN SNF. The facility must provide resource, in accorda part, routine and emmeet the needs of emmedical residents with lost or dentist.	ietary Manager on May 13, in the kitchen, confirmed the been removed and the ice lipe was not elevated to exslash into the ice drain pipe. I confirmed the facility failed to exironment in the kitchen.	F	1111	to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review these results and i deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance. F411 1. Corrective action The Social Services Director referred Resident #213 for dent services immediately on 05/15. The Resident chose to refuse deservices on 05/16/13. 2. Identification Audit of dental assessments wa	tal /13. ental	
	The findings included	d:			completed on 05/20/13 by nursi management to determine that residents were receiving service needed.		וווור

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4L3111

Facility ID: TN3309

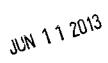
If continuation sheet Page 15 of 21



INTERMENT OF DEFICIENCES IN PROVIDER OR SUPPLIER (X1) PROVIDER OR SUPPLIERCLING NUMBER: A SULDING B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 1028 RUNYAN DR CHATTANOOGA, TN 37405 FORCH CORRECTION AND PREPRINT OF DEFICIENCES (EACH DEFICIENCY MUST BE PREPRINT OF DEFICIENCES) TAG FOR SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCE ON TYPL) RESULATORY OR LSC IDENTIFYING INFORMATION) FREETY ADDRESS, CITY, STATE, 2IP CODE 1028 RUNYAN DR CHATTANOOGA, TN 37405 FROVIDERS PLAN OF CORRECTION FROUDERS PLAN OF CORRECTION FROVIDERS PLAN OF CORRECTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROVIDERS PLAN OF CORRECTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROVIDERS PLAN OF CORRECTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROVIDERS PLAN OF CORRECTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROM THE CONSTRUCTION FROM THE CORRECTION CHATTANOOGA, TN 37405 FROM THE CONSTRUCTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROM THE CONSTRUCTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROM THE CONSTRUCTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROM THE CONSTRUCTION FROM THE CONSTRUCTION CHATTANOOGA, TN 37405 FROM THE CORRECTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION THE CONSTRUCTION CHATTANOOGA, TN 37405 FROM THE CONSTRUCTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION THE CONSTRUCTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION THE CONSTRUCTION FROM THE CONSTRUCTION FROM THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE ALITY OF THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTRUCTION THE CONSTR	CENTE	KS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	D. 0938-0391
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LIFE CARE CENTER OF RED BANK (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) F 411 Continued From page 15 Resident #213 was admitted to the facility on May 2, 2013, with diagnoses including Fractured Vertebrae, Chronic Airway Obstruction, Urinary Tract Infection, and Anxiety. Observation and interview with the resident on May 13, at 3:40 p.m., in the resident revealed he/she would like to see a dentist and the facility had not offered dental services to the resident was alert and oriented and had loose/missing teeth. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented and had loose/missing teeth. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented and had loose/missing teeth. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented and had loose/missing teeth. Interview with the facility Social Worker on May 15, 2013, at 3:00 p.m., in the Social Worker's office, revealed the dentish thad visited the facility on May 14, 2013, and the resident was not on the list to be seen by the dentist. Continued direview confirmed the resident was not offered dental services. F 431 SS=D F 431 F 433 SS=D F 434 Controlled from page 15 Resident #213 was admitted to the facility on May 14, 2013, and the resident was not on the list to be seen by the dentist And visited the facility on May 14, 2013, and the resident was not on the list to be seen by the dentist. Continued direview confirmed the resident was not offered dental services. F 431 F 431 F 431 F 431 F 431 F 433 F 433 F 433 F 434 Controlled drugs is sifficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is mainteined and periodically			445240	B. WING	·	n,	5/15/2013
F 411 Facility must employ or obtain the services of a licensed pharmacist who establishes a system of records are in order and that an account of all controlled drugs in sufficient dealing, and accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs in sufficient dealign controlled drugs in sufficient dealign of a forecast and compliance.			BANK	<u></u>	1020 RUNYAN DR	ZIP CODE	0/10/2013
Resident #213 was admitted to the facility on May 2, 2013, with diagnoses including Fractured Vertebrae, Chronic Airwey Obstruction, Urinary Treat Infection, and Anxiety. Observation and interview with the resident on May 13, at 3:40 p.m., in the resident's room, revealed the resident bed. Continued observation revealed the resident had loose/missing teeth The resident revealed he/she would like to see a dentist and the facility had not offered dental services to the resident. Medical record review of a Nursing Admission Assessment dated May 2, 2013, revealed the resident was alert and oriented and had loose/missing teeth. Interview with the facility Social Worker on May 15, 2013, at 3:00 p.m., in the Social Worker's office, revealed the dentist had visited the facility on May 14, 2013, and the resident was not on the list to be seen by the dentist. Continued interview confirmed the resident was not offered dental services. F 431 F 431 F 431 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintained and periodically controlled drugs is maintain	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T	OF CORRECTION ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
Drugs and biologicals used in the facility must be	F 431 SS=D	Resident #213 was May 2, 2013, with d Vertebrae, Chronic. Tract Infection, and Observation and int May 13, at 3:40 p.m revealed the resider bed. Continued obshad loose/missing to he/she would like to had not offered den: Medical record reviet Assessment dated in resident was alert at loose/missing teeth. Interview with the farm 15, 2013, at 3:00 p.m office, revealed the confirmed the resides services. 483.60(b), (d), (e) DI LABEL/STORE DRU The facility must empart of records of receipt controlled drugs in subsection of the confirmed than a licensed pharmacis of records are in order a controlled drugs is mireconciled.	admitted to the facility on iagnoses including Fractured Airway Obstruction, Urinary Anxiety. erview with the resident on in the resident's room, in the resident's room, in the sitting on the side of the servation revealed the resident seen a dentist and the facility tal services to the resident. Ew of a Nursing Admission May 2, 2013, revealed the individual oriented and had cility Social Worker on May in., in the Social Worker's dentist had visited the facility in the resident was not on the extension. Continued interview int was not offered dental RUG RECORDS, IGS & BIOLOGICALS Doloy or obtain the services of sit who establishes a system and disposition of all infficient detail to enable an in; and determines that drug and that an account of all aintained and periodically		3. Measurement Staff Development provided educations 05/17/13 regarding services based on ac assessment indication Coordinators will convert weekly for 4 weeks for 2 months to assure with dental needs are Dentist. The Unit Consubmit the audit resure Director of Nursing of Nursing of the Quality Assurance consisting of the Measurement of the Quality Assurance consisting of the Measurement of the Quality Assurance consisting of the Measurement of the Quality Assurance consisting of the Measurement of the Canada and at least 3 other staff men months. The Quality Committee will review and if deemed necessary committee, additional may be provided: the evaluated/revised and reviewed for 3 months 100% compliance is a Executive Director will receive will reviewed for 3 months 100% compliance is a Executive Director will receive the control of the security of the control of the security of the control	Coordinator al inservice on provision of Imission ons. Unit omplete audits then monthly re residents e referred to coordinators will alts to the each week. ing will the audits to e Committee, dical Director, Director of mbers for two Assurance w these results ary by the education process or/ the audits s or until chieved. The ll monitor to	

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	labeled in accordan professional princip appropriate accesso instructions, and the applicable. In accordance with a facility must store al locked compartmen controls, and permit have access to the Interpretation of the facility must propermanently affixed controlled drugs listed Comprehensive Drug Control Act of 1976 abuse, except when package drug distrib	ce with currently accepted les, and include the bry and cautionary expiration date when State and Federal laws, the drugs and biologicals in the under proper temperature only authorized personnel to	F 43	 F431 Corrective action Medication was discarded container in resident #38 r immediately by the nurse of 05/14/13. Identification Audit completed of resider Nebulizers was completed 05/14/13 by the nursing 	oom on nts with on
1 - - -	by: Based on medical re and interview, the fac medications properly forty-four sampled re The findings included Resident #38 was ad March 22, 2013, with Depressive Disorder	for one resident #38 of sidents.		management team to assure nebulizer contained any resimedication. 3. Measurement Staff Development Coordin provided inservice on medicatorage with nurses on 05/1 Unit Coordinators will commandits weekly for 4 weeks the monthly for 2 months to assure compliance. The Unit Coordinators will submit the audit results	nator cation 7/13. plete hen sure dinators
	- Respirate	ory Failure.		Director of Nursing each we	ek. 7/1/13
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room. 483.65 INFECTION SPREAD, LINENS The facility must est Infection Control Pro safe, sanitary and co to help prevent the d of disease and infect (a) Infection Control The facility must esta Program under whic (1) Investigates, con in the facility; (2) Decides what pro	ablish and maintain an agram designed to provide a amfortable environment and levelopment and transmission tion. Program ablish an Infection Control it - trols, and prevents infections	F 441	1. Corrective action The nurse for resident #62 and the CNA for # 96 were inserviced immediately with regard to handwashing by the Staff Development Coordinator on 05/13/13. Nurse instructed on use of barrier material immediately by Director of Nursing on 05/13/13. Nurse instructed on use of barrier material immediately by Director		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR IS Continued From pa Medical record revier recapitulation orders the resident receive for shortness of bre nebulizer" Observation on May Licensed Practical National revealers and instered medication revealers and instered medication revealers and instered medication revealers and instered medication be given that had be interview on May 14 and instered medication be given that had be interview on May 14 and instered medication revealers and instered medication revealers and instered medication be given that had be interview on May 14 and instered medication room. 483.65 INFECTION SPREAD, LINENS The facility must estable for the facility must estable for the facility must estable for the facility must estable for the facility must estable for the facility; (2) Decides what proint in the facility; (2) Decides what proint in the facility in the facility; (2) Decides what proint in the facility; (2) Decides what proint in the facility in the facility; (2) Decides what proint in the facility; (2) Decides what proint in the facility in the facility; (2) Decides what proint in the facility in the facility; (2) Decides what proint in the facility in the facility in the facility; (2) Decides what proint in the facility in the facili	PROVIDER OR SUPPLIER RE CENTER OF RED BANK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Medical record review of the Physician's recapitulation orders dated May 1, 2013, revealed the resident received "Budesonide (medication for shortness of breath)twice dailyvia nebulizer" Observation on May 14, 2013, at 8:21 a.m., with Licensed Practical Nurse (LPN) #4 revealed resident #38 sitting on the side of the bed eating breakfast. Continued observation revealed LPN #4 administered medications with the meal. Observation revealed the charge nurse told resident would return to give the Budesonide via nebulizer. The resident then stated there was already a medication left in the nebulizer ready to be given that had been left in the room. Interview on May 14, 2013, at 8:29 a.m., with LPN #4, outside the resident room confirmed the resident's medication was not to be left in the room. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	PROVIDER OR SUPPLIER RE CENTER OF RED BANK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Continued From page 17 Medical record review of the Physician's recapitulation orders dated May 1, 2013, revealed the resident received " Budesonide (medication for shortness of breath)twice dailyvia nebulizer" Observation on May 14, 2013, at 8:21 a.m., with Licensed Practical Nurse (LPN) #4 revealed resident #38 sitting on the side of the bed eating breakfast. Continued observation revealed LPN #4 administered medications with the meal. Observation revealed the charge nurse told resident would return to give the Budesonide via nebulizer. 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Interview on On May 14, 2013, at 8:29 a.m., with LPN #4, outside the resident room confirmed the resident's medication was not to be left in the room of the resident room confirmed the resident's medication room confirmed the resident's medication room confirmed the resident's medication for the resident reviewed for 3 months or until 100% compliance is achieved. The Executive Director, Director of Nursing, and if deemed necessary by the committee, additional may be provided: the process evaluated/revised and or the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director information to ensure continued compliance. If 441 1. Corrective action The nurse for re	



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F 441	(3) Maintains a reco actions related to in (b) Preventing Spres (1) When the Infecti determines that a re- prevent the spread isolate the resident. (2) The facility must communicable disea- from direct contact will tra- direct contact will tra- (3) The facility must hands after each dir hand washing is indi- professional practice (c) Linens Personnel must hand	and of incidents and corrective fections. and of Infection for Control Program esident needs isolation to of infection, the facility must prohibit employees with a case or infected skin lesions with residents or their food, if insmit the disease. The require staff to wash their ect resident contact for which is cated by accepted	F 44	2	Residents in the facility could affected by hand sanitation and barrier use practices. Measurement The Staff Development Coordinator conducted educat inservices to staff on 05/13/13 regarding handwashing and medical equipment handling. Staff Development Coordinator Unit Coordinators will conducted handwashing observation audit weekly for 4 weeks and month for 2 months to assure complicated submit the results to the Director of Nursing. Hand san will be placed in the resident reby maintenance staff during the week of June 10, 2013 to ensure	ional The or and ot t tly ance itizer ooms e	
	by: Based on facility polinterview, the facility medications and medications and medications and medications and hands at aff washed hands at (#62, #96) of forty-through the findings included Review of facility policions.	dical equipment in a sanitary ents (#209, #63) and ensure after entering isolation rooms ee sampled residents. I: Cy Hand Hygiene. Ensed Practical Nurse (LPN)		4	hand sanitation compliance. Monitoring The Director of Nursing will submit the results of the audits the Quality Assurance Commiconsisting of the Medical Director, Director of Nursing, and at least 3 other summbers for two months. The Quality Assurance Committee review these results and if dee necessary by the committee, additional education may be	ittee, ector, of aaff	7/1/13

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	#5 on May 13, 2013 #209's room, reveal resident's bathroom medication cups co thinner) and Pepcid (used to perform blo sink, washed the ha cups and the glucor medications, and ch sugar with the gluco Interview with LPN # p.m., in the south ha been "dirty". Contin nurse failed to follow Observation with Re May 14, 2013, at 5:1 room, revealed the f bathroom, placed the Refresh eye drops o the hands, retrieved applied gloves, and a resident #63. Interview with RN #1 p.m., in the hallway, "dirty". Continued in failed to follow infecti Observation on May revealed Certified Nur resident #62's room i the room without was another resident's roo Review of a list of res	It is a series of the series o	F 4	41	provided: the process evaluated, revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.			
F	provided by the facilit	y revealed resident #62 was					לוווד	

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	in contact isolation organism. Interview with CNA p.m., in the hallway, wash the hands after in contact isolation. Observation on May revealed Licensed Fentered resident #96 medications without exited the room with Further observation isolation hanging on Interview with LPN # a.m., outside the rest LPN failed to wash the resident's room. Review of a list of reprovided by the facilitin contact isolation for Organism. Interview with LPN # 11:00 a.m. till 11:30 a station, confirmed the contact isolation for Norganisms in the urinvisitors the importance after contact with the	for a Multi-Drug Resistant #2 on May 13, 2013, at 12:27 confirmed the CNA failed to er entering a resident's room 13, 2013, at 10:00 a.m., Practical Nurse (LPN) #4 b's room to administer gloved hands and then tout washing the hands. revealed supplies for contact the resident's room door. 44 on May 13, 2013, at 10:05 bident's room, confirmed the he hands before exiting the sidents on contact isolation ty revealed resident #96 was or a Multi-Drug Resistant 2 on May 15, 2013, from a.m., at the 200 nurse's er facility placed residents in	F 44			
						7/1/13